Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

TEXAS HEALTH LLC
SUITE 204
5455 LA SIERRA DRIVE
DALLAS TX 75231

Respondent Name
ACE AMERICAN INSURANCE CO

Carrier's Austin Representative
Box Number 15

MFDR Tracking Number
M4-10-2906-01

MFDR Date Received
February 22, 2010

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The patient was referred for the Work Hardening Program. The services were provided and the claims were paid incorrectly. CPT code 97546 WHCA was billed at 5.25, 4.5 & 4.75 units but were not paid for the full units. Please refer to the attached HCFA for further reference."

Amount in Dispute: $113.49

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The EOBs indicate that the provider was correctly paid pursuant to their contract with First Health."

Response Submitted by: Downs Stanford, P.C.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
October 20, 2009, October 21, 2009 and October 22, 2009	97546-WH-CA x 3 dates of service	$113.49	$113.49

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code §134.204 sets out the Medical Fee Guideline for Workers' Compensation Specific Services.

3. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits
   - C – Any network reduction is in accordance with the network referenced above.
   - BL – This bill is a reconsideration of a previously reviewed bill
   - 45 – Charges exceed your contracted/legislated fee arrangement
   - W1 – The bill is a reconsideration of a previously reviewed bill
   - BL – Additional allowance is not recommended as this claim was paid in accordance with state guidelines, usual/customary policies
   - BL – To avoid duplicate bill denial, for all recon/adjustments/additional pymnt request, submit a copy of this EOR or clear notation
   - W1 – Workers' Compensation State Fee Schedule Adjustment
   - 45 – This line was included in the reconsideration of this previously reviewed bill

Issues

1. Was the workers' compensation insurance carrier entitled to pay the health care provider at a contracted rate?
2. Did the requestor submit documentation to support the billing of 97546-WH-CA?
3. Is the requestor entitled to reimbursement?

Findings

1. The insurance carrier reduced disputed services with reason code" C – Any network reduction is in accordance with the network referenced above * Focus/First Health" and "45 – Charges exceed your contracted/legislated fee arrangement." Review of the submitted information found insufficient documentation to support that the disputed services were subject to a contractual fee arrangement between the parties to this dispute. Nevertheless, on August 3, 2010 the Division requested the respondent to provide a copy of the referenced contract as well as documentation to support notification to the healthcare provider, as required by 28 Texas Administrative Code §133.4, that the insurance carrier had been given access to the contracted fee arrangement. Review of the submitted information finds that the documentation does not support notification to the healthcare provider in the time and manner required. The Division concludes that pursuant to §133.4(g), the insurance carrier is not entitled to pay the health care provider at a contracted fee. Consequently, per §133.4(h), the disputed services will be reviewed for payment in accordance with applicable Division rules and fee guidelines.
2. Per 28 Texas Administrative Code § 134.204(h) "The following shall be applied to Return To Work Rehabilitation Programs for billing and reimbursement of Work Conditioning/General Occupational Rehabilitation Programs, Work Hardening/Comprehensive Occupational Rehabilitation Programs, Chronic Pain Management/Interdisciplinary Pain Rehabilitation Programs, and Outpatient Medical Rehabilitation Programs. To qualify as a Division Return to Work Rehabilitation Program, a program should meet the specific program standards for the program as listed in the most recent Commission on Accreditation of Rehabilitation Facilities (CARF) Medical Rehabilitation Standards Manual, which includes active participation in recovery and return to work planning by the injured employee, employer and payor or carrier."

   Per 28 Texas Administrative Code § 134.204(n) "The following Division Modifiers shall be used by HCPs billing professional medical services for correct coding, reporting, billing, and reimbursement of the procedure codes. (1) CA, Commission on Accreditation of Rehabilitation Facilities (CARF) Accredited programs--This modifier shall be used when a HCP bills for a Return To Work Rehabilitation Program that is CARF accredited."

   Review of the submitted documentation in the form of CMS-1500's document that the requestor billed for CPT code 97546-WH-CA on October 20, 2009, October 21, 2009 and October 22, 2009. The CPT code 97546-WH identifies that the requestor billed for a work hardening program. Modifier –CA identifies that the work hardening program is CARF accredited. As a result, the disputed service will be reviewed pursuant to 28 Texas Administrative Code § 134.204 (h)(3).
3. Per 28 Texas Administrative Code § 134.204(h)(3) "For Division purposes, Comprehensive Occupational Rehabilitation Programs, as defined in the CARF manual, are considered Work Hardening. (A) The first two hours of each session shall be billed and reimbursed as one unit, using CPT Code 97545 with modifier "WH." Each additional hour shall be billed using CPT Code 97546 with modifier "WH." CARF accredited Programs shall add "CA" as a second modifier. (B) Reimbursement shall be $64 per hour. Units of less than one hour shall be prorated by 15 minute increments. A single 15 minute increment may be billed and reimbursed if greater than or equal to 8 minutes and less than 23 minutes."

The requestor seeks a total reimbursement for CPT code 97546-WH-CA in the amount of $113.49 for dates of service October 20, 2009, October 21, 2009 and October 22, 2009.

The requestor seeks an additional payment of $26.91 for date of service October 20, 2009. Review of the CMS-1500 documents that the requestor billed for 5.25 units of CPT code 97546-WH-CA. Reimbursement shall be $64 per hour. Units of less than one hour shall be prorated by 15 minute increments. A single 15 minute increment may be billed and reimbursed if greater than or equal to 8 minutes and less than 23 minutes. The MAR reimbursement for 5.25 units is $336.00, minus the insurance carrier's payment of $241.89 equals a balance due of $94.11. The requestor seeks an additional reimbursement in the amount of $26.91, therefore, this amount is recommended.

The requestor seeks an additional payment of $36.89 for date of service October 21, 2009. Review of the CMS-1500 documents that the requestor billed for 4.5 units of CPT code 97546-WH-CA. Reimbursement shall be $64 per hour. Units of less than one hour shall be prorated by 15 minute increments. A single 15 minute increment may be billed and reimbursed if greater than or equal to 8 minutes and less than 23 minutes. The MAR reimbursement for 4.5 units is $288.00, minus the insurance carrier's payment of $193.51 equals a balance due of $94.49. The requestor seeks an additional reimbursement in the amount of $36.89, therefore, this amount is recommended.

The requestor seeks additional reimbursement of $49.69 for date of service October 22, 2009. Review of the CMS-1500 documents that the requestor billed for 4.75 units of CPT code 97546-WH-CA. Reimbursement is calculated at a single 15 minute increment may be billed and reimbursed if greater than or equal to 8 minutes and less than 23 minutes. The MAR reimbursement for 4.75 units is $304, minus the insurance carrier's payment of $193.51 equals a balance due of $110.49. The requestor seeks an additional reimbursement in the amount of $49.69, therefore, this amount is recommended.

Review of the submitted documentation supports that the requestor is entitled to an additional reimbursement in the amount of $113.49 for the disputed CPT code 97546-Wh-CA rendered on October 20, 2009, October 21, 2009 and October 22, 2009.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $113.49.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $113.49 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	October 24, 2013 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.